Performing 'pragmatic holism': professionalization and the holistic discourse of non-medically qualified acupuncturists and homeopaths in the UK

Word count: 7,994 including abstract, footnotes and references

Abstract

Complementary and Alternative Medicine (CAM) practitioners have often utilised ‘holism’ as a key identification-mark of their practice, distancing themselves from ‘the reductionist biomedicine’. However, the past couple of decades have witnessed increased engagement of several CAM in professionalization which includes a degree of biomedical alignment while ‘reducing’ holistic claims in order to provide practice with a ‘credible outlook’ and move closer to the mainstream, a development which challenges the role of holism in CAM practices. This paper explores *the strategies* by which two groups of CAM practitioners, non-medically qualified (NMQ) acupuncturists and homeopaths in the UK, *pragmatically accommodate* holistic notions as a *professional resource*, a process of negotiation between maintaining their holistic premise on the one hand and the drive to professionalise and enhance their societal status on the other. Based on in-depth interviews with NMQ acupuncture and homeopathy practitioners and school principals, textual analysis of practitioners’ websites and observation of practice, the findings demonstrate the dynamic approach to ‘holism’ in CAM practice. This discourse, through which practitioners use a range of strategies in order to ‘narrow’ or ‘expand’ their holistic expression, can be described as ‘pragmatic holism’, by

which they try to make gains from the formalization/standardization processes, without losing the therapies' holistic outlook and appeal.

Keywords: complementary and alternative medicine, acupuncture, homeopathy, holism, professionalization

Introduction

A number of scholars discussed the challenge of Complementary and Alternative Medicine (CAM) practitioners to maintain their holistic premise during their efforts to move closer to mainstream medical care via professionalization (for example Cant 2009, Cant and Sharma 1999, Saks 2001, Welsh *et al* 2004, Wiese *et al* 2010), or in the process of the 'domestication' of CAM (Fadlon 2004). The aim of this study is to consider how two groups of CAM in the UK, non-medically qualified (NMQ) practitioners of acupuncture and homeopathy, negotiate the holistic notions that are embedded in their theories and practices during their professionalization efforts. Furthermore, this study considers the various strategies used by practitioners in order to maintain and utilise holism as a professional resource.

The dynamic nature of the holistic discourse in CAM

In order to contextualise 'the problem' at hand, it is first important to consider the meanings of *holism* and *professionalization* in the context of CAM practice

and the proposed relationship between them. The term ‘Complementary and Alternative Medicine’ refers to ‘a broad set of health care practices that are not part of a country’s own tradition, or not integrated into its dominant health care system’ (WHO 2002:7). This definition points at the therapies’ political marginality, but also at the diversity of CAM practices and the difficulty to identify clearly-distinguished mutual historical, clinical or philosophical bases for CAM (Coulter and Willis 2004). Nevertheless, whilst a lack of state support coupled with an institutionalized biomedical marginality continues to characterise CAM, this group of practices is also shaped by shared ideological ground, namely discourses of holism (Sointu 2012), even if the conceptualisation of holism is arguably fluid (Cant and Sharma 1999) limited, or at times conflicting its premise (Baer 2003, Coward 1989, Lowenberg and Davis 1994, Scott 1999). In particular, the emphasis of the holistic discourse in CAM is on ‘the whole person’ and the interconnectedness between body, mind, emotions and spirit in the social context, on increased patient empowerment and engagement in the therapeutic act, and vitality (Fadlon 2004, Scott 1999). Sociological and historical accounts describe how, after a long period of marginalisation, the popularity of CAM in industrialised countries re-emerged from the late 1960s as part of a medical counter-culture that challenged the modernistic scientific enterprise (Goldstein 1999; Saks 1998). It called for a shift

in responsibility from professionals to individuals, for a more pluralistic and personalised healthcare, and for greater responsiveness to consumers' voices (Bivins 2001, Cant 2009). Much of the counter-culture critique focused on the 'reductionist-dualistic nature' of modern medicine, whilst emphasising the 'holistic nature' of CAM therapies as an increasingly popular alternative (Porter 2002, Rosenberg 1998). As mainstream healthcare became increasingly dominated by biomedicine, CAM therapies gradually found themselves placed outside the mainstream (Saks 2001). Here they were well positioned to express their critique towards biomedicine, and to 'cumulatively illustrate the cultural tenacity and explanatory power of holistic ideas as well as their widespread cultural diffusion' (Rosenberg 1998: 345). Indeed, holistic notions at the heart of the CAM discourse contributed to its appeal and are used as a rhetorical strategy for gaining popularity (Keshset 2009). However, while the increasing demand for CAM has been often discussed as a resistance to biomedical dominance, some point at the pragmatic dual utilisation of CAM by its consumers, *alongside* (rather than instead of) conventional medicine (Cant 2009, Fadlon 2004, Thomas and Coleman 2004).

Several authors discussed un-intended challenges, dilemmas and paradoxes inherent in CAM's holistic claims (Baer *et al.* 1998, Baer 2003, Coward 1989,

Lowenberg and Davis 1994). They argue that CAM practices, too, tend to focus on the individual person and her/his behaviour and promote 'victim-blaming' whilst failing to consider broader socio-political aetiologies. On the other hand, recent sociological explorations extended the 'traditional' holistic presentation of CAM, suggesting that the motivation of CAM consumers reflects not only a sense of personal responsibility, but also an enhancement of agency and a change in the perception of the body 'from a natural, biological object to an experiencing subject' (Baarts and Pedersen 2009: 730). Sointu (2012) discussed holism in CAM as 'a means of claiming the power to define meaning back from biomedicine and locating it instead in the context of lived experience and personal interpretation' (2012: 142). McLean (2005), in reference to spiritual healing practices, suggested that indeed there is a paradox within the individualistic focus in practice: while it may promote victim-blaming, it can also enhance both creativity and empowerment in the healing act and in what he describes as the constructing of healing reality by both the patient and the practitioner.

It is essential at this point to make a couple of clarifications. Firstly, while it is helpful to explore this holistic discourse in relation to the critique of biomedicine, it is definitely not my intention to argue that biomedicine is 'purely reductionist'

or ‘un-holistic’ in nature or that CAM is the exact opposite. In fact, the holistic/reductionist debate was discussed in biomedicine long before the medical counter-culture (Lawrence and Weisz 1998) and it is part of education and practice in disciplines such as general practice, nursing, social psychiatry, psychology and the public health movement (Hasegawa *et al*. 2005, Hill 2003, Lawrence and Weisz 1998, Rosenberg 1998). Nevertheless, as suggested by Bates (2002), ‘given the remarkable complexities of the therapeutic act, such superficiality could hardly be avoided’ (Bates 2002: 14). Secondly, this publication is not an analysis of the ‘degree of holism’ embedded in the philosophy or practice of acupuncture or homeopathy. Rather, I draw on the intense use made by NMQ acupuncturists and homeopaths *themselves* of the term ‘holism’ and the claims attached to it, i.e. *their own* claims for holism. Indeed, the term ‘holism’ appears in abundance in both practitioner-groups’ online information, professional bodies’ practice and educational guidelines, acupuncture and homeopathy schools’ information and syllabi, as well as in practitioners’ own websites. Moreover, bearing in mind the diversity of CAM practices, a certain degree of generalisation is applied here. For example, while acupuncture and homeopathy, the two most popular CAM in high income countries (Ong *et al.* 2005) both share a number of similar holistic notions (Goldstein 1999), the two derive from very different historical and philosophical

roots. Acupuncture is an 'interventionist' modality involving the insertion of needles under the skin to promote the flow of *qi,* the claimed invisible energy that runs in the meridians, while homeopathy, leans more heavily on the consultation and on constructing the personal biography of the patient in the search for a homeopathic remedy[1]. Such variations imply that the centrality of holism in different CAM practices varies. Furthermore, it varies also *within* each individual practice, between the different schools, and is affected by the sustained influence of individual charismatic teachers and their unique interpretation/emphases on elements of theory and practice (see for example Cant, 1996 in relation to homeopathy and Birch, 1998 in relation to acupuncture).

Professionalization and the challenge of holistic expression in CAM

In their discussion of CAM in the UK, Cant and Sharma used the term *professionalization* to refer to 'a type of occupational change and formation that involves unification, standardisation, and the acquisition of external legitimacy'

[1] Homeopaths argue that illness is primarily a disturbance in the 'vital force' which is manifested in the 'totality of symptoms' - physical, mental or emotional - that is unique to each patient. In the course of the homeopathic interview the practitioner is looking to identify the remedy that best corresponds with the patient's totality of symptoms.

(1996:157). The transition from an occupation to a profession involves assuming a dominant position in a division of labour, gaining control/jurisdiction over the determination of the substance of own work, as well as the conditions under which this knowledge is practiced (Friedson 1970). Saks (2001) used the perspective of social closure to demonstrate the marginalisation of CAM and the exclusion of CAM knowledge by the medical profession. Social closure refers to the way occupations seek to regulate market conditions in their favour, minimising competition from others by employing strategies which restrict access to a limited group (Parkin, 1974). They do so by closing off entry to the profession to all but those that are 'suitably qualified' and who meet the conditions determined by the occupational group (Saks, 2001). By using biomedicine's powerful political position in society, the medical profession limited the access of CAM practitioners to vital resources such as research funding and medical education (ibid) and 'exclude[d] others from gaining jurisdictional control or state suctioned self-regulation' (Welsh *et al* 2004: 218).

Over the past three decades NMQ homeopaths (Cant and Sharma 1996) and acupuncturists (Saks 2001), as well as several other CAM therapies in the UK, have engaged in efforts to legitimatize their knowledge claims through professionalization strategies. These efforts include attempts to formalise and

standardise professional knowledge and training programs, which often involve the tempering of holistic knowledge claims, the same claims that contributed to the very rise of CAM as part of the medical counter-culture (Cant 2009). Such strategies include an alignment of CAM knowledge to the scientific paradigm, infusion of biomedical knowledge in CAM education, as well as employing randomised controlled trials to provide CAM practice with a 'credible outlook' (Cant and Sharma 1996). Using Gieryn's (1983) account of boundary work and knowledge claims, Welsh *et al* (2004) argue that such infusion of medical sciences is used by CAM groups to demarcate 'credible' practitioners with 'valid' knowledge-base from those CAM practitioners who are not. The boundary work perspective points at the way scientists attribute certain qualities to science, which are then used to demarcate between science and non-science and distinguish scientists from the less authoritative non-scientists by establishing their epistemic authority (Gieryn 1983). However, such biomedical alignment in CAM challenges holistic, anti-reductionist claims, which are contested in an environment that is dominated by biomedicine (Hirschkorn 2006). It is not surprising then that historically the process of formalising acupuncture and homeopathy education involved disagreements amongst practitioners and schools regarding the degree of alignment with biomedicine, fear of losing the autonomy over the form and the content of the taught knowledge, and, centrally,

fear of losing the holistic nature of practice (Cant and Sharma 1999, Clarke *et al.* 2004).

Methods

Data collection

The findings described here are part of a larger study exploring the way NMQ acupuncturists and homeopaths in the UK, in their efforts to professionalize and formalise their educational structure, negotiate holistic concepts that are embedded in their theory, practices and discourses. The data presented here was gathered using mixed-methods, in-depth qualitative approach. This paper particularly draws on narratives from 21 in-depth interviews with practitioners of acupuncture and homeopathy in London and the South of England; a review of NMQ acupuncture and homeopathy practitioners' websites; and notes from observations in one homeopathy practice and one acupuncture practice. While it is important to recognise the relatively small sample size of interviews, the mixed-methods approach helped increase the depth and, to a certain degree, the transferability of the findings. The field of research is made up by various

actors who shape contemporary acupuncture/homeopathy practice from ‘within’: practitioners, their schools and school leaders, and their professional bodies. Therefore it was important to include the viewpoints of all these actors in order to find out how they negotiate the impact of consumers, the media, higher education institutions, the medical profession, and the government on practice. Furthermore, the chosen methodological approach allowed for an enhanced engagement with the field of investigation and thus a detailed description of the research setting and of my findings, moving closer towards a ‘thicker description‘ and an increased degree of transferability (Polit and Beck 2010).

Interview participants were recruited based on the following criteria: a) members of the leading professional bodies pursuing professionalization for NMQ acupuncturists (BAcC) and homeopaths (SoH), b) active practitioners, and c) from diverse demographic settings, rural and urban, in London and South of England. In order to reach the desired sample size, a total of 200 practitioners listed on the BAcC and SoH online register were approached via personal email providing information about the study and an invitation to participate. It is possible that the low response rate of approximately 10 percent reflects the increased intensity of attacks on CAM at the time that this research was conducted. In particular such attacks were from within higher education (Corbyn

2008), the media and a high profile investigation by the House of Commons Science and Technology Committee (2010) into homeopathy which was, to say the least, negative towards homeopathy. It is therefore not surprising that some practitioners expressed suspicion of my motives as a researcher and were not eager to express their views.

All participants practised in private settings, with five of them also working additionally alongside biomedical practitioners. Practice experience was diverse, from 1 to 30 years in practice. Interviews took place in two clusters, during 2008 and during 2010. The sample of 21 interviewees was made up of 14 female and 7 male practitioners, out of whom 10 practiced acupuncture 8 practiced homeopathies, and 3 practiced both. Although 10 of the participants did have additional medical or allied medical qualifications, including conventional medicine, nursing, veterinary medicine and a paramedic, these practitioners chose to practice the *non-medical* approach to acupuncture/homeopathy practice. Amongst the participants there were four school principals. Interviews lasted between 45 minutes and two hours. Practitioners were first asked to describe their practice biography, consider challenges to their practice, and provide descriptions of real ‘cases’ from practice, using as much detail as possible. Ethical approval for the interviews

was first obtained from the Departmental Ethics Committee at the University (granted in August, 2007), and later from the NHS National Research Ethics Service (NRES) (granted 22nd February, 2009). NRES approval was sought to allow the interviewing of practitioners who also practice in the NHS. Participants' anonymity was safeguarded by using pseudonyms and all interviews were based on the informed consent Moreover, with regard to online information obtained from practitioners' websites, all citations used in this paper are paraphrased, to avoid linking such online information to individual practitioners.

Data analysis

All interviews were taped and transcribed verbatim, and were then sent back to interviewees to check for accuracy. Interviews were analysed using qualitative data analysis (Mayring 2000) whereby the text is systematically reduced to the context of the research questions, and is then examined in the context of key categories deriving from the theoretical models which drive the research ('contextual units'). At this stage the data is broken down to smaller 'analytical units' to filter out particular themes and any emerging thematic structures deriving from the text. Whenever practitioners had their own website, interviews

were complemented with the practitioner reflecting on the content of their website in the context of the research questions and contextual units. Data analysis was conducted in two clusters, after the first period of data collection and then again, once all other interviews were completed and transcribed, which allowed for an intermediate consideration of the accumulating data in relation to the research questions. All findings were analysed by the lead researcher and later re-visited and discussed during interval meetings with the research team.

Findings

Approximately four decades after the re-emergence of CAM, holism is still strongly embedded in the therapies' rhetoric. Holistic notions were frequently discussed, with no exception, by all of the interviewees, and are included, in one way or another, in their professional websites. Such notions are also included in the educational and practice guidelines of both therapies' leading professional bodies pursuing professionalization, the Society of Homeopathy and the British Acupuncture Council, and their accredited schools' syllabi. What often surfaced in practitioners' narratives was that the common attachment of holism to CAM and the parallel fluidity of holism bring about a certain frustration

amongst practitioners, fearing that it diffuses their professional identity rather than sharpening and defining it. For example Sue, who runs two busy practices of both acupuncture and homeopathy and is a lecturer in Chinese Medicine, stated the following:

> ….maybe that's what complementary medicine has done, you know, 'we are not this reductionist approach; we are this holistic approach instead' [...] So maybe we can let go of it, if we are becoming more defined as a group, if we are becoming more respected, maybe we don't need that concept so much anymore. Western medicine is opening its arms a little bit to us and we are learning to be less like sulky teenagers and to be grown up about it.

Nicola, an acupuncturist and a school principal, fears that holism, which she perceives as central to acupuncture philosophy and practice, has 'lost its meaning':

> I always hoped that one of the students at the college will research the actual meaning of holism because that's where we all started from but nobody knows what it really means anymore.

Such frustration demonstrates the tension between the dynamic nature of the holistic discourse as *a strategy* or a *professional resource* and the more 'essentialist' perception of holism as a 'basic, inherent character' of theory and practice. For example, on the SoH website homeopathy is described as 'a form

of *holistic medicine* in which treatment is *tailored to the individual*' (i.e. the 'essential' perspective) that 'can be used alongside conventional medicine when necessary to give an integrated approach to your healthcare' (i.e. the professional resource perspective). Furthermore, under the website's research section there is a list of clinical research and RCTs supporting homeopathy in the treatment of certain *conditions,* which somewhat moves away from the focus on 'the whole person'. In describing medical acupuncture the BAcC suggests that 'what makes this system so uniquely suited to modern life is that physical, emotional and mental are seen as interdependent' (i.e. the 'essential' holistic perspective), while the same section points out that 'a growing body of evidence-based clinical research shows that traditional acupuncture safely treats a wide range of common health problems' (i.e. the professional resource perspective).

The following two sections present two perspectives in which practitioners negotiate holism. The first is in relation to the *meaning of holism* as part of consumers' expectations as well as in relation to the unique style of acupuncture and homeopathy practice and with it the personal 'holistic affinity' of individual practitioners. The second is in relation to *political and economic forces surrounding the professionalization* of both practitioner-groups', including

the pressure by the medical profession for biomedical alignment and the increased emphasis on biomedical research evidence. Here I also refer to consumers' expectations for such biomedical alignment in what is a biomedical-driven market.

Pragmatic accommodation in relation to epistemological issues surrounding holism

The expression of holism is linked to a number of issues which shape the practitioner's interpretation of holism and the expectation for holistic approach by consumers. These include the holistic interpretation of the various acupuncture or homeopathy schools/styles adopted by the practitioner, the holistic worldview of the individual practitioner – i.e. her/his own engagement with holistic principles which often requires relying on intuitive skills and on interpretive autonomy – and finally, consumers' expectation of holism. In relation to the latter, Cant (2009), points at a certain consumerist paradox. On the one hand, a number of studies suggest that CAM users are more likely to have holistic orientation to health and appreciate 'the lengthy, holistic, personalized and equitable client-practitioner encounter often encouraged in

‘non-orthodox’ consultations’ (ibid: 181), which points at a consumer expectation whereby the biomedical perspective may be challenged. At the same time the biomedical alignment in CAM training and practice and the biomedical appeal to ‘science’ as an epistemic authority has an impact on the ‘credibility-status’ of CAM. The fact that CAM is mostly practiced in the private sector only places further pressure on CAM practitioners to respond to this paradoxical demand in an effort to win over consumers. Participants in this research study adopted a number of strategies to maintain their holistic appeal and ‘ethos’ while, at the same time, adhering to the pressure to appear ‘scientifically credible’. Furthermore, and rarely explored in the literature, is how, in order to appeal to consumers, practitioners strategically narrow their holistic approach by focusing on *symptoms* and ‘*conditions*’, which seemingly contradicts the whole person view inherent in traditional acupuncture and in homeopathy. This approach was apparent in nearly all of the participants’ (both acupuncturists and homeopaths) websites in which they list *conditions* that they successfully treat. A number of practitioners admitted that this common symptomatic presentation in CAM is merely a compromise resulting from having to compete in a private market that is dominated by biomedicine, where consumers are accustomed to a ‘quick fix’ treatment of ‘the condition’.

Martyn has been practicing classical homeopathy for 14 years and co-owns a centre for holistic health. On a number of occasions during the interview he made reference to the constitutional nature of the homeopathic treatment, which aims to match the uniqueness of each patient so that, in principle, each patient (as opposed to each symptom) receives a tailor-made homeopathic remedy. However, he admits that his patients often expect quick results, and this expectation may alter his ideal holistic approach. In describing a patient suffering from Ménière's disease (a rare disorder that affects the inner ear, often causing vertigo, tinnitus, hearing loss, and a feeling of pressure deep inside the ear), his homeopathic approach appears rather 'symptomatic' in nature. He treats each symptom in isolation, rather than consider the manifestation of *the accumulation of these symptoms together* in the context of 'the totality of symptoms' or 'the whole person':

> I treated the presenting symptoms so for the dizziness I prescribed Cocculus Indicus, which is a snake remedy, fantastic for vertigo and dizziness and is concomitant to the dizziness. She had sickness and nausea so I gave her [the remedy] nux vomica. And because she got incredibly anxious and she suffers from hypertension, I gave her aconite.

Chris, who has been practicing both traditional acupuncture and classical homeopathy for over 10 years, emphasises ‘the condition’ rather than ‘the person’ in guiding his therapeutic choice:

> If somebody comes to me with back pain I would tend to say that my approach is less holistic. I would probably tend to use certain points-protocols and not take into account so much the holistic view. But if somebody came to me with eczema, then my approach would be more holistic.

Another strategy of making practice more approachable to consumers, while narrowing the holistic view, is the introduction of ‘remote homeopathic consultation’. Mick, for example, has practiced classical homeopathy for 25 years and offers online or phone consultations. He admits that such ‘remote consultation’ compromises both the depth and the intimate nature of the homeopathic interview:

> Of course, I would much prefer, even if it is somebody who has a sore throat, that they would come in and see me. The results are better because it is much easier to establish a rapport when you can see them.

The strategic negotiation of holism can also be a response to the practice setting, which may inspire the utilisation of ‘more’ or ‘less’ holistic practice

styles. For example, Lucy practices traditional acupuncture and is also a university lecturer in biomedical science. She describes traditional acupuncture as a 'powerful approach which provides constitutional treatment', but at the same time she practises cosmetic acupuncture which is the application of acupuncture as part of beauty therapy. She described the tension between applying a 'deep', 'constitutional' acupuncture and a 'superficial', symptomatic treatment. As she points out, the different practice-settings involve different consumerist expectations:

> I am working on Saturdays at the physiotherapy centre and I am working Mondays at a beauty centre. They are two completely different environments. The physiotherapy centre is kind of more medical. And then the beauty place [where Lucy practices cosmetic acupuncture] is not just for nice spa treatments. They also do Botox and peels and the whole lot, kind of full on. *So you get a completely different market base in each setting* [my emphasis], so trying to fit the acupuncture practice in both ways is interesting.

On the one hand Lucy describes acupuncture, and in particular 'five elements'[2] acupuncture, as holistic in its capacity to treat 'the root cause' on a 'constitutional' level. On the other, she somewhat lowers the degree of her holistic engagement during her cosmetic acupuncture practice, as expected

[2] 'Traditional Chinese medicine' (TCM) acupuncture style can be seen as less holistic than 'five elements' or 'stems and branches' acupuncture styles, in that the latter is more symptoms-orientated and less concerned with the patient's unique constitution or the body, mind and spirit interconnectedness.

from her in this particular setting. Lucy also discussed the impact of the style of acupuncture practice on her holistic engagement:

> If you get it right, 'five elements' is amazing. It is a constitutional treatment so patients will feel so much better. You know you can transform their lives so to speak in the way that they feel and their outlook. But, if they have, say, arthritis, you might not do much about that [with 'five elements acupuncture']

It appears that through time practitioners develop a certain interpretation of holism which they feel most confident with. This is often influenced by how comfortable they are delving into their patients' biography, which is often part of treating the whole person. A number of practitioners, particularly homeopaths, *do* rely heavily on their intuitive skills to construct their therapeutic approach. During the homeopathic interview, patients are encouraged to bring into the therapeutic encounter intimate biographic social, psychological and emotional details. Such details are often used by the practitioner to make diagnostic and therapeutic choices. Having practised for nearly 30 years, Helen describes homeopathy as 'a journey to enlightenment', during which she escorts patients through life changing experiences:

> Successful homeopathic consultation is about getting results and having patients transforming their lives. It is about changing consciousness. [...] I

> mean this might sound strange and it might sound negative, but I cannot tell you how many women have left their partners, and said: 'I would never have done it without homeopathy'. [...]Homeopathy is about enlightenment.

An example of the way by which such interpretive autonomy is utilised in the quest for a whole person constitutional approach, is the following case which Louise recalled from her homeopathy practice. Here she is shifting between a carefully structured, systematic homeopathic prescribing, to complete reliance on her intuition:

> I had the strangest experience the other day with a little boy who was autistic. He was really stressed out whenever there is no balance and he could not make decisions. He told me that he wanted to have a space-machine so that he could go back to the time when the dinosaurs were here and find out the real reason why they were extinct. So I looked at the periodic table [many homeopathic remedies originate from elements in the periodic table] I thought, 'Well let's go for something in the middle [of the table]' because he wants balance. […] I looked in the middle and near the middle was Iridium, which is a remedy I do not know. And I looked up the remedy and it said: 'This is thought to have been responsible for the extinction of the dinosaurs', and I was amazed. […] And then when I looked at the remedy picture all sorts of other issues fitted the case.

Marilyn, who first trained as an MD but now solely practices and lectures traditional acupuncture, sees holistic practice as a sort of an amalgamation of

broad and diverse esoteric knowledge which, combined with indeterminate skills, allows capturing the uniqueness of the individual patient:

> When I look at a human being I don‘t want to only see that she or he has a certain deficiency, I want to see a whole human being. This is the main part of what is holistic. Because there are endless variations and permutations of what a human being is, so I want to use the systems I know and which is a culmination of everything I‘ve ever learnt. I want to use *also my senses and my intuition* [my emphasis].

In contrast, four of the study participants expressed certain unease with what they described as the potentially ‘overly-judgmental’, ‘overly-subjective’ and ‘overly-intuitive’ nature of some practice styles in both acupuncture and homeopathy. Chris recalls his ‘five elements’ acupuncture training:

> I was quite uncomfortable with some of the approaches in ‘five elements’ acupuncture training that I was expected to use to try and figure out which patients were. For example, we were supposed to ask non-specific questions but use certain tone of voice or a certain manner to ask a question. In some ways I felt that the skill is too highly tuned and too subjective to try and interpret somebody‘s particular reaction.

Penny, a homeopathy school principal, describes how she ‘disarms’ the expectation for practitioner’s interpretive autonomy at the beginning of her homeopathic consultations:

> When I begin a consultation with somebody who knows nothing about homeopathy, which is often the case, I will say […] I am not sitting here thinking that clearly when you had that trauma when you were four years old this has led to your Oedipus complex or whatever. […] I am not judging you. I am not your moral superior. Sometimes you can see their shoulders relax as if they think 'thank god for that'...

Pragmatic holism in relation to political and economic forces surrounding professionalization

The provision of CAM in Britain has been significantly shaped by the influence of conventional biomedicine on which CAM gained legitimacy and to what extent (Cant 2009, Saks 2001). Furthermore, CAM's provision in mainstream settings has often been contained by conventional doctors (see for example studies in the UK by Broom and Tovey 2007, Cant *et al* 2011, in Israel by Shuval *et al.* 2002, or in Canada by Hollenberg 2006) and has been judged using biomedical research and criteria (Barry 2006, Broom and Tovey 2007, Jackson and Scambler 2007, Keshet 2009) while compromising holistic concepts (Wiese *et al* 2010).

Strategically, moderating the degree of holism better allows practitioners who work in more mainstream settings to enjoy the benefit of epistemological legitimacy that is part of such settings. While this research only includes a small number of practitioners working in a biomedical setting, it is very possible that they too develop a 'sense of increased credibility' of being in an 'enhanced professional position'. Even more, due it its uncertain societal position and the 'lack of sufficient scientific evidence' to accept or reject its interventions and outcomes (Coulter and Wilis 2004), CAM practitioners face pressure to align some of their holistic notions and claims with that of biomedicine, in the quest to gain public credibility under the supremacy of 'scientific' evidence (Cant *et al* 2011). As a result, NMQ acupuncturists and homeopaths work towards formalising their training programs, increasing their status as 'professionals' and establishing a gap between 'competent' and 'dangerous' practitioners by means of increasing biomedical input in their accredited (and often university validated) training programmes (Clarke *et al* 2004, Givati 2012, Jackson and Scambler 2007, Welsh *et al* 2004). Therefore, it is possible to view acupuncture and homeopathy practitioners as using holism as a professional resource to strategically operate between a number of political and societal 'push' and 'pull' factors, between the desire to move closer to mainstream while maintaining the holistic premise and attraction of their practice. But *how* do practitioners

negotiate holism in practice in relation to these factors? *What strategies* are being employed?

Firstly, *the majority of the participants* made reference on their websites to biomedical research and RCTs that generated evidence in support of their therapy's effectiveness. Secondly, and paradoxically, practitioners commonly integrated biomedical terms *to enhance the credibility of their holistic claims*. For example, on his website, Mick, who was trained at the school of the renowned Greek homeopath George Vithoulkas, argues that '…homeopathy is the profoundest and most gentle stimulus possible to the immune system'. He describes how the body sometimes operates an 'unsuitable immune response, or as he describes it, runs 'the wrong immune programme'. This 'wrong' immune response, he argues, leads to a pattern of recurring medical conditions such as asthma or eczema. Homeopathy, he suggests, provides the immune system with the 'correct information' so that it can generate better immune response. This attachment of homeopathy to the immune response, which is a comprehensively described biological system, can be seen as explaining the mechanism of homeopathy using a biomedical narrative. Possibly, Mick used this attachment to support the holistic claim of homeopathy's ability to

encourage the body's natural healing forces. Yet, this focus on homeopathy's suggested effect on the immune system somewhat contradicts 'the whole person argument' which is so central to homeopathy philosophy and practice. Another example is the way Nicola, on her website, describes acupuncture's ability 'to restore and maintain health and promote a state of homeostasis', by stimulating the patient's own healing forces. The term 'homeostasis' refers to the tendency of the organism to regulate internal conditions regardless of outside conditions and thus maintain equilibrium within the internal environment via a number of biological parameters. In this case Nicola utilised this biomedical concept to support her holistic claim that acupuncture '….catalyses homeostasis by stimulating the self-healing powers of the body'. Such translation of CAM holistic concepts into biomedical rhetoric to increase legitimacy was also reported in the Israeli setting where CAM practitioners avoid using 'CAM concepts' and use biomedical terminology instead to describe CAM processes, or adopt external biomedical symbols such as wearing a white coat and a stethoscope (Shuval and Averbuch 2012).

The drive to increase biomedical research evidence on CAM (see House Of Lords Select Committee 2000; sections 7.10-7.30) was often criticised for RCTs

inability to capture the individualised, non-standardised nature of CAM therapies (Barry 2006, Jackson and Scambler 2007, Keshet 2009). Nevertheless, NMQ acupuncture and homeopathy professional bodies, their schools and practitioners, frequently utilise biomedical research evidence to boost the profile of their practice and attach their practice with biomedical 'scientific credibility'. The following case is an example of how RCTs are utilised to 'support holism' in practice. The notes below were taken during an observation of a homeopathic consultation by Martyn, a classical homeopath who in his interview commonly referred to the holistic and the intuitive nature of homeopathic prescribing. At the same time, he often utilised the findings from biomedical research to boost his recommendations and enhance their credibility:

The holistic health centre is situated near a town centre. It is shared by several CAM practitioners including homeopaths, acupuncturists and chiropractors, as well as a psychotherapist. The patient, Jo, is a tall, slender woman in her forties. This is a follow-up to her first consultation which took place one month earlier. Jo suffers from rheumatoid arthritis, which has progressed in the past few months. Her doctor suggested changing her current medication to more aggressive drug therapy but Joe is determined to avoid this treatment, hoping

that homeopathy will offer a gentler alternative. Jo also suffers from bad migraines that tend to appear every weekend. Martyn is friendly and attentive. He is not trying to dictate or control the conversation, but rather to encourage Jo to speak as openly as possible. Martyn asks Jo to describe her condition following her month-long homeopathic treatment. ‘There is an improvement’ she says. The most striking improvement is in her migraine attacks. Since she started the homeopathic treatment, her migraines nearly disappeared. There is also some improvement with her arthritic pain, although not as striking. On at least three occasions Martyn made reference to certain randomised controlled trials, and how ‘clinical research suggests that this treatment is useful for…’ He talks at length about a particular clinical trial on homeopathy that he is part of. In their previous meeting Martyn prescribed Jo with a ‘constitutional remedy’ (the single remedy that corresponds with the patient’s ‘totality of symptoms’), supported by one ‘symptomatic’ remedy (corresponding with an ‘isolated’ symptom). Martyn also provided nutritional guidelines and several food supplements to take on a daily basis, including fish oil capsules. He is keen to discuss Jo’s diet although she clearly struggles with this aspect of the consultation. ‘I am not very good with that’; ‘it is difficult’; ‘soy milk is awful!’; ‘never liked vegetables’, she says. Once again, he turns to scientific research to support his recommendation for fish oil capsules. ‘Do you take this

supplement?' he asks. 'Not yet....' Jo answers. 'You know, research seems to be positive about this supplement, although it does not seem to work for everyone', he says. Martyn opens a drawer and hands Joe a homeopathic remedy. 'This is for you', he says. 'I got it from a clinical trial that I am involved with. It is a 'complex' homeopathic remedy (a ready-made combination of remedies to treat certain conditions) for arthritis. Use it next to the constitutional remedy if symptoms get worse'.

Conclusion

As discussed by Cant (2009), the position of CAM in Britain is mainstream yet marginalised: on the one hand it is 'a mainstream activity, an aspect of common experience' (p.193), which is also reflected in an increasing integration of CAM into the health service, while, on the other hand, it remains largely unregulated, still practiced mainly in the private sector. When integrated, it is contained under the jurisdictional boundaries of conventional medicine and is measured by biomedical 'scientific' criteria. As demonstrated in this paper, being in this position leads NMQ acupuncturists and homeopaths to strategically move back and forth between their holistic ideology and its appeal and the drive to

formalise and professionalise in the quest to enhance their societal stature, an approach that I have termed *Pragmatic Holism*. Holism is utilised as a professional resource, part of the therapeutic arsenal of acupuncturists and homeopaths, which is narrowed and expanded differently by individual practitioners in relation to audiences, settings and circumstances. Strategies to enhance or limit the holistic expression in practice include: increasing or reducing the degree of reliance on interpretive autonomy and intuition; adopting a more 'symptomatic' or a more 'constitutional/individualistic' approach to practice; utilising a 'more' or a 'less' holistic practice-style; and increasing the utilisation of RCTs as well as biomedical explanatory reasoning to support holistic therapeutic and diagnostic claims in practice.

Bearing in mind the sample size, the focus on two CAM practices and the defined geographical borders of the study, more studies are required, both in other geographical settings as well as in other CAM practices, in order to increase the transferability of the findings presented here. Furthermore, it should be noted that the tension deriving from developing standardised clinical practice that is increasingly being shaped by biomedical criteria and which, arguably, takes away from the indeterminate, experience-based, intuitive nature of expert knowledge and the artistic skills of the practitioner, is also debated in

other social care and allied health professions (see for example Timmermans & Mauck, 2005). Although this study points at the *strategic nature* of holism in CAM practice, it is clear that the holistic discourse is interwoven in the acupuncture's and homeopathy's philosophy, theory and practices and is therefore *an essential* part of practitioners' professional identity. From a broader perspective, by observing the utilisation of the holistic discourse as *dynamic and flexible*, rather than as essentialist yet illusive concept in need of coherent definition, this paper provides an insight into practitioners' strategies of negotiating their political and societal status while recognising the fluidity of expert knowledge during the process of professional-political negotiation.

Acknowledgements: I would like to thank the study participants for their time and openness. I would like to thank Dr. Janine Teering and four anonymous reviewers for their valuable comments and suggestions. Thank you to Dr. Kieron Hatton and to Dr. Ann Dewey for their help during the research process.

References

Baarts, C. and Pedersen, K. (2009) Derivative benefits: exploring the body through complementary and alternative medicine. *Sociology of Health and Illness,* 31, 5, 719-733.

Baer, H., Hays, J., McCLendon, N., McGoldrick, N. and Vespucci, R. (1998) The holistic health movement in the San Francisco bay area: Some preliminary observations. *Social Science & Medicine,* 47, 10, 1495-1501.

Baer, H. (2003) The work of Andrew Weil and Deepak Chopra – two holistic health/New Age gurus: A critique of the holistic health/New Age movements. *Medical Anthropology Quarterly,* 17, 2, 233-250.

Barry, C. (2006) The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science & Medicine,* 62, 11, 2646–2657.

Bates, D. (2002) Why not call modern medicine 'alternative'? *Annals of American Academy of Political and Social Sciences,* 583, 1, 12-28.

Birch, S. (1998) Diversity and acupuncture: Acupuncture is not a coherent or historically stable tradition. In A. Vickers (Ed.), *Examining complementary medicine*. Cheltenham: Stanley Thornes.

Bivins, R. (2001) The needle and the Lancet: Acupuncture in Britain, 1683-2000. *Acupuncture in Medicine*, 19, 1, 2-14.

Broom, A. and Tovey, P. (2007) Therapuethic pluralism? Evidence, power and legitimacy in UK cancer services. *Sociology of Health and Illness*, 29, 4, 551-69.

Cant, S. (1996) From Charismatic teaching to professional training: The legitimating of knowledge and the creation of trust in homoeopathy and chiropractic. In T. Heller, G. Lee-Treweek, J. Katz, J. Stone and S. Spurr (Eds.), *Perspectives on complementary and alternative medicine: A reader*. London: Routledge.

Cant, S. (2009) Mainstream marginality: 'Non-orthodox' medicine in an 'orthodox' health service. In J. Gabe and M. Calnan (Eds.), *The new sociology of health service*. London: Routledge.

Cant, S., Watts, P., and Ruston, A. (2011) Negotiating competency, professionalism and risk: the integration of complementary and alternative medicine by nurses and midwives in NHS hospitals. *Social Science and Medicine*, 72, 4, 529-536.

Cant, S. and Sharma, U. (1996) Demarcation and transformation within homeopathic knowledge. A strategy of professionalism. *Social Science & Medicine,* 42, 4, 579-588.

Cant, S. and Sharma, U. (1999) *New medical pluralism? Alternative medicine, doctors, patients and the state.* London: UCL Press.

Clarke, B., Doel, A. and Sergott, J. (2004) No alternative? The regulation and professionalization of complementary and alternative medicine in the United Kingdom. *Health and Place,* 10, 4, 329-338.

Colquhoun, D. (2007) Science degrees without the science. *Nature,* 446, 22, 373-374.

Corbyn, Z. (2008, October 30) Unwelcomed complements. *The Times Higher Education* [On line]. Accessed 10th November 2010 from http://www.timeshighereducation.co.uk/story.asp?storycode=404104

Coulter, I., and Willis, E. (2004) The rise and rise of complementary and alternative medicine: A sociological perspective. *Medical Journal of Australia*, 180, 11, 587–9.

Coward, R. (1989) *The whole truth: The myth of alternative medicine*. London: Faber and Faber.

Fadlon, J. (2004) Meridians, chakras, and psycho-neuro-immunology: the dematerializing body and the domestication of alternative medicine. *Body & Society,* 10, 4, 69-86.

Freidson, E. (1970) *Profession of Medicine*. *A study of the sociology of allied knowledge.* New York: Harper and Row.

Gieryn, T. (1983) Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review,* 48, 6, 781-795.

Givati, A. (2012) The holistic discourse and formalising education of non-medically qualified acupuncturists and homeopaths in England, Unpublished doctoral thesis.

Goldstein, M. (1999) *Alternative healthcare: medicine, miracle, or mirage?* Philadelphia: temple University Press.

Hasegawa, H., Reilly, D., Mercer, S. and Bikker, A. (2005) Holism in primary care: The views of Scotland's general practitioners. *Primary Health Care Research and Development,* 6, 4, 320–328.

Hill, F. (2003) Towards a new model for health promotion? An analysis of complementary and alternative medicine and models of health promotion. *Health Education Journal,* 62, 4, 369-380.

Hirschkorn, K. (2006) Exclusive versus everyday forms of professional knowledge: Legitimacy claims in conventional and alternative medicine. *Sociology of Health and Illness*, 28, 5, 533-557.

Hollenberg, D. (2006) Unchartered ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care setting. *Social Science and Medicine,* 62, 3, 731-744.

House of Commons Science & Technology Committee. (2010). Fourth report, evidence check 2: Homeopathy.[Electronic version].

House of Lords Science and Technology Select Committee. (2000) *Sixth report: Complementary and alternative medicine.* [Electronic version]

Isbell, B. (2004) Finding the right complementary therapies course, *Complementary Therapies in Nursing and Midwifery*, 10, 2, 92-96

Jackson, S. and Scambler, G. (2007) Perceptions of evidence-based medicine: traditional acupuncturists in the UK and resistance to biomedical models of evaluation. *Sociology of Health & Illness,* 29, 3, 412-429.

Keshet, Y. (2009) The untenable boundaries of biomedical knowledge: epistemologies and rhetoric strategies in the debate over evaluating complementary and alternative medicine. *Health*, 13, 2, 131-155.

Lawrence, C. and Weisz, G. (1998) *Greater than the parts: holism in biomedicine, 1920-1950*. Oxford: Oxford University Press.

Lowenberg, J. and Davis, F. (1994) Beyond medicalisation-demedicalisation: The case of holistic health. *Sociology of Health and Illness,* 16, 5, 579-599.

Mayring, P. (2000) Qualitative content analysis. *FQS Forum, Qualitative Social Research Sozialforschung*, 1, 2.

McLean, S. (2005) 'The illness is part of the person': discourses of blame, individual responsibility and individuation at the centre for spiritual healing in the North of England. *Sociology of Health and Illness, 27, 5, 628-648.*

Ong, C., Bodeker, G., Grundy, C., Burford, G. and Shein, K. (2005) *WHO global atlas of traditional, complementary and alternative medicine.* Kobe: World Health Organisation.

Parkin, F. (1974). *Strategies of social closure in class structure*. London: Tavistock.

Polit, D. and Beck, C. (2010) Generalization in quantitative and qualitative research: myths and strategies. *International Journal of Nursing Studies*, 47, 11, 1451-1458.

Porter, R. (2002) *Blood and guts*. London: W.W. Norton & Company.

Rosenberg, C. (1998) Holism in twentieth-century medicine. In C. Lawrence and G. Weisz (Eds.), *Greater than the parts: holism in biomedicine, 1920-1950*. Oxford: Oxford University Press.

Saks, M. (1998) Medicine and complementary medicine: challenge and change. In G. Scambler and P. Higgs (Eds.), *Modernity, medicine and health: medical* sociology towards 2000. London: Routledge.

Saks, M. (2001) Alternative medicine and the health care division of labour: present trends and future prospects. *Current Sociology,* 49, 3, 119-134.

Scott, A. (1999) Paradoxes of holism: Some problems in developing an anti-oppressive medical practice. *Health,* 3, 2, 131-149.

Shuval, J., and Averbuch, E. (2012) *Alternative and Bio-Medicine in Israel: Boundaries and Bridges.* Brighton: Academic Studies Press.

Shuval, J., Mizrachi, N. and Smettanikov, E. (2002) Entering the well-guarded fortress: alternative practitioners in hospital settings. *Social Science and Medicine,* 55, 10, 1745-1755.

Sointu, E. (2012) *Theorizing Complementary and Alternative Medicines: Wellbeing, Self, Gender, Class.* Basingstoke: Palgrave Macmillan.

Timmermans, S., & Mauck, A. (2005) The promises and pitfalls of evidence-based medicine. *Health Affairs, 24*(1), 18-28.

Thomas K. and Coleman P. (2004) Use of complementary or alternative medicine in a general population in Great Britain. Results from the National Omnibus Survey. *Journal of Public Health,* 26, 2, 152-157.

The Society of Homeopaths. (n.d.) What happens when you see a homeopath? Accessed 12th June 2013 from http://www.homeopathy-soh.org/about-homeopathy/what-is-homeopathy/what-happens-when-you-see-a-homeopath/

Welsh, S., Kelner, M., Wellman, B. and Boon, H. (2004) Moving forward? Complementary and alternative practitioners seeking self regulation. *Sociology of Health and Illness,* 26, 2, 216–241.

Wiese, M., Oster, C., and Pincombe, J. (2010) Understanding the emerging relationship between complementary medicine and mainstream health care: A review of the literature. *Health*, 14, 3, 326–342.

World Health Organisation (2002). *WHO Traditional Medicine Strategy 2002-2005*. Geneva, WHO. Retrieved July 1, 2012, from http://apps.who.int/medicinedocs/pdf/s2297e/s2297e.pdf